STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Targeted Infection Control Survey/COVID-19 Focused Survey conducted by the Kansas Department on Aging and Disability (KDADS) on 06/30/2020, and the Centers for Medicare and Medicaid (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID 19. The 2567 was electronically sent to the facility on 07/01/2020.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/01/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 880	Continued From page 1 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 2	F 880		

The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:

The facility reported a census of 49 residents. Based on observation, interview, and record review, the facility failed to follow the Center for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prevent transmission of COVID-19. Record review revealed the facility failed to ensure all staff and visitors were screened appropriately on 20 occasions from 06/01/20 through 06/30/20. Per observation, the facility failed to ensure hand hygiene performed appropriately during ice pass and failed to ensure all staff donned/doffed the appropriate personal protective equipment (PPE) appropriately when entering and exiting a room of a resident that was on quarantine. The failure to screen appropriately, perform proper hand hygiene, and don/doff appropriate PPE, increased the risk of transmission of the pandemic COVID-19 virus to the vulnerable residents of the facility.

Findings included:

- Record review of the "Staff/Medical Personnel/Vendor Health Screening" form, dated 06/01 through 06/30/2020 lacked documentation of a temperature recorded and/or symptoms and/or other screening questions answered on 20 occurrences.

On 06/30/20 at 04:12 PM, Administrative Nurse D confirmed she would expect a temperature to be recorded on the form and not just answered "no" next to question that asked if a fever was present.

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F 880	Continued From page 3	F 880		

Furthermore, Administrative Nurse D confirmed that she would expect all questions to be answered on the form.

On 7/1/2020 at 09:41 AM, Administrative Nurse D confirmed the expectations for staff and visitor screening included the completion of the form in its entirety to include the temperatures and the questionnaire form. She confirmed the facility did not have a plan in place for auditing the completion of the screening. The Human Resource staff member collected the forms and scanned them to maintain records but dd not audit. The facility had a dedicated screener on duty from 05:00 AM through 06:00 PM and the expectation was that they would ensure the completion of the documentation.

The facility policy, "Novel Coronavirus (2019-nCoV) (COVID-19)," dated 05/05/20, indicated that upon entry, the visitor will complete the facility's pre-screening questionnaire. Facilities will vigilantly monitor any possible infected individuals, including residents, staff members, and essential visitors throughout the day. Furthermore, all staff will be tested for elevated temperature prior to his/her shift.

Additionally, a brief tour was conducted of the facility at 09:00 AM. Several resident rooms had a sign on the door frame to indicate standard isolation and for staff to wear mask and gloves when in the room, and that nursing and housekeeping staff only in the room.

06/30/20 at 09:02 am, Administrative Nurse D revealed that staff put a new mask on when entering a quarantine room and dispose of it when exiting.

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F 880	Continued From page 4 On 06/30/20 at 02:31 PM, Certified Nurse Aide (CNA) M, exited a resident room after adding ice to the water pitcher and assisting with a blanket without performing hand hygiene. Then CNA M entered another room, brought pitcher out to ice cart and added ice, returned the pitcher to the room, and exited the room with performing hand hygiene. CNA M then entered another resident room, that was on quarantine and failed to change mask when going in the room and when exiting. After performing hand hygiene she entered another resident room, added ice to the pitcher from the cart, adjusted the resident's blinds, adjusted her mask, adjusted her pants, scratched behind her ear, shut the door to the room, and did not perform hand hygiene before moving on to another room. On 06/30/20 at 02:47 PM, CNA M revealed she was not aware she needed to put on a different mask when going into a resident room that was on quarantine, and hand hygiene should be performed after contact with resident water pitcher and other surfaces. On 06/30/20 at 02:53 PM, Licensed Nurse (LN) G confirmed that when ice is being passed out to the residents, the staff should sanitize or wash their hands between water pitchers. Furthermore, she confirmed that when entering a room of a resident on quarantine that the facemask was to be changed, then removed when exiting the room and another facemask applied. On 06/30/20 at 03:20 PM, Administrative Nurse D confirmed that hand hygiene should be performed after each resident during ice pass, and when entering a resident room on quarantine a new	F 880		

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F 880	Continued From page 5	F 880		

mask should be placed and when exiting the room.

On 07/01/20 at 12:16 PM, Administrative staff A revealed besides our regular infection control processes, we do not have a specific process to use in the quarantine rooms.

The facility policy "Hand Hygiene," dated 05/19/20, that indications for hand washing or using alcohol-based hand rub included before and after contact with inanimate objects.

The facility policy "COVID-19 Isolation Precautions," dated 05/19/20, directed that if a resident is seen in medical situations outside of the facility that the following isolation precautions will be instituted for 14 days. This included that staff will utilize appropriate PPE during all cares or while in the room.

The facility failed to screen appropriately, perform proper hand hygiene, and don/doff appropriate PPE, which increased the risk of transmission of the pandemic COVID-19 virus to the vulnerable residents of the facility.